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**Payer Consolidation and Its Impact on  
Provider Revenue: Strategies to Ensure  
Negotiating Power, Healthier Cash Flow  
and a Competitive Market**

A White Paper

February 2008

Consolidation is nothing new to many industries across the country. And while consolidation can be viewed as beneficial by some stakeholders, it's clear that suppliers in an industry that is dominated by only a few players are the clear losers.

Take Wal-Mart, for example. Few will argue that consumers can get the cheapest products at Wal-Mart, but at what cost. Wal-Mart benefits from its retail expansion and market domination, and consumers benefit from finding the least expensive product. Yet, suppliers are literally caught in the middle.

Suppliers of these low-cost products must sell them as cheaply as possible to Wal-Mart and are pressured to cut costs and deliver product that meets their specific requirements. If suppliers can't meet that price point, then Wal-Mart, with its huge purchasing power, can move on to the next supplier. In other words, suppliers don't have any bargaining or negotiating power – they either meet Wal-Mart demands or lose business to a retailer that may comprise the largest part of their business.

The U.S. drugstore industry is another example of a consolidation surge that has resulted in stores such

as Rite Aid, Walgreen and CVS controlling a majority of the real-estate across the country (*International Herald Tribune, August 25, 2006*), giving them enormous economies of scale and tremendous influence. Once again, suppliers are the ones that suffer. The large drugstores can now decide promotional allowances, payment terms and service levels, in essence, dictating terms to suppliers.

In the healthcare industry, suppliers – doctors and hospitals – are getting squeezed as well, as payers merge and consolidate power.

### **Payer Consolidation - No End in Sight**

The country's largest health insurers continue to merge and consolidate, as illustrated below in Figure 1. According to the American Medical Association's latest 2007 report, *Competition in Health Insurance, A Comprehensive Study of U.S. Markets*, in the majority of metropolitan statistical areas (MSAs), a single health insurer dominates the market, undermining competition in hundreds of markets across the country. Over the five years since AMA's first study, the largest insurers have pursued aggressive acquisition strategies – purchasing 11 smaller health insurers since 2000.

<b>Healthcare Payer Consolidation 1992-Present</b>	<b>Result</b>	<b>Reported Enrollment</b>
QualChoice, Atrium, WellChoice, Lumenos, Anthem, (9 others incl. 7 BCBS plans) Wellpoint (Cobalt/United Wisconsin, RightChoice, 5 others)	Wellpoint	34 million
FiServ Health, Sierra Health, Arnett, John Deere, PacifiCare, (incl. Pacific Life), Oxford Health, Great Lakes, Definity, MAMSI, Golden Rule, 12 others	United Healthcare	28 million
HMS Health (PPOM, Sloan's Lake, Mountain Medical), Chickering, New York Life (NYLCare); Prudential HealthCare, US Healthcare, 4 others	Aetna	16 million
KMG America, CHA, CorpHealth, Memorial Hermann, ChoiceCare, PCA, EmpheSys, Care Network, Group Health	Humana	11 Million
GreatWest, Sagamore Health Network, Choicelinx, Managed Care Consultants, Healthsource (CYN, Provident, CentraMass)	CIGNA Health Plans	10 Million
Universal Care, Physician Health, Foundation Health (Intergroup, Care Florida, Coventry MediCorp), Atlantic Health, MD Enterprise, Qual-Med	Health Net Systems	7 million
Florida Healthcare Administrators, Mutual of Omaha, (partial), Concentra Workers' Comp, First Health, OmniCare, Altius, Prudential, Partners Health, 14 others	Coventry Health Care	3 Million

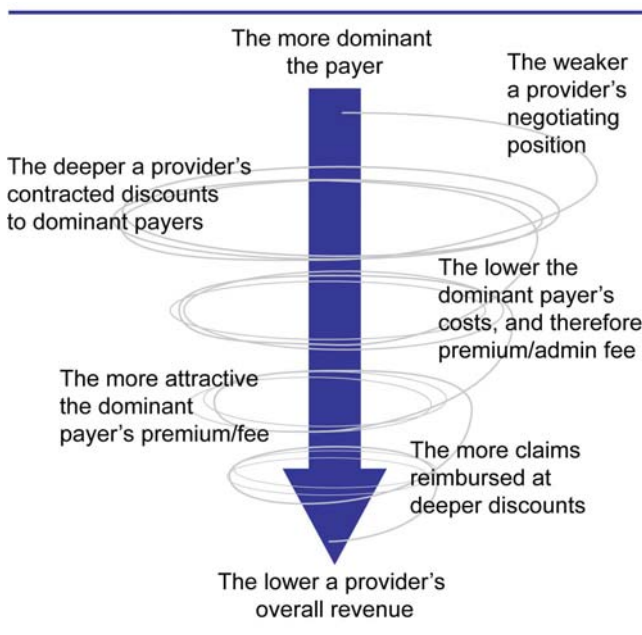
**Figure 1 - Large payers continue to get bigger**

### Providers' Revenue Stream Under Siege

On a daily basis, providers juggle competing, but critical demands, from reducing medical errors and meeting regulatory compliance requirements to managing the cost of unfunded care and meeting pay for performance guidelines. However, at the end of the day, providers must make their business run profitably, ensure cash flow and generate enough revenue to make their office or organization viable for the long-term.

Payer consolidation is eating more and more into providers' revenue and with no end in sight, things aren't going to get better anytime soon. How is it adversely impacting providers? Consider Figure 2.

- As payers become more and more dominant in a providers' service area, **providers have an ever weakening negotiating position**. They either accept the very deep discount offered by the dominant payer or risk losing access to hundreds or thousands of patients.
- When a provider accepts the dominant payers' deep discount, **that payer reaps the benefits of lower medical costs** and then attracts even more members with lower premiums or administrative fees.



**Figure 2 - The cycle of a provider's diminishing revenue stream**

- With enticing cut-rate premiums or administrative fees, even more members shift to the dominant payer and now even **more claims are reimbursed at the deepest discounts, further eroding a providers' revenue stream.**

As revenue shrinks, providers are, understandably, left to make some tough choices. They simply want to stop giving away their revenue and stem the "bleeding" of their business.

Many providers are forced to take a long and hard look at current contractual arrangements with both dominant payers that are demanding the deepest discounts and with mid-tier market players that have more moderate discounts.

### The Mid-Tier Market – Their Loss is Your Loss

The mid-tier payer market comprises a range of entities that serve different types of organizations, typically with more variation and customization in benefit design, including traditional HMOs/PPOs, third-party administrators (TPAs) serving self-insured employers, regionally-focused insurers, and national specialty insurers.

This mid-market, just like providers, is in a tug of war with dominant payers, trying to stay in business despite extreme cost pressures. The independent networks that mid-tier insurers and health plan administrators typically use have always offered more amenable, yet still competitive discounts to providers. **However, as large payers have become more aggressive, the discounts for the middle market have eroded substantially.** Today, the discount gap between the largest payer in a given market and the rest of the field is often quite wide and can be seen in most U.S. markets.

For example, in the New York City market, the largest payer demands a 60 percent average blended discount across all claim types, while a mid-tier payer may only receive a 45 percent discount from the same hospital. (source: *privately-funded research from Thomson Medstat*).

To recap: As dominant payers exact deeper discounts from providers, they can afford to offer lower than average premium rates or admin fees. This in turn, creates a market shift. Members now begin to move from a higher paying plan to a lower paying market dominant plan. This loss of business for the mid-tier market now becomes a loss of revenue for the provider.

In order to remain competitive, or perhaps simply survive, mid-tier payers need to receive from providers discounts that are more on par with the dominant payers. However, providers desperate to offset the deep discounts demanded by dominant payers are loathe to negotiate deeper discounts with mid-tier payers. This might make sense in the short-term, but the long-term implications are worrisome, to say the least. ***Providers who continue to support a wide disparity in discounts will find themselves in a profit free fall if the mid-tier payer market is not kept alive and healthy.***

### **Strategies for the Long-Term**

The mid-tier market is losing members to dominant payers in every market, while providers are seeing less and less “take home pay” as, according to the AMA, “the physician’s role is being systematically undermined as dominant insurers are able to impose take-it-or-leave-it contracts that directly affect the provision of patient care and the patient/physician relationship.”

And, as providers refuse to make concessions on discounts with the independent networks that mid-tier payers use, the problem only worsens, and the consolidation of the insurance market speeds up.

The long-term strategy for providers is to help bolster the mid-tier payer market by keeping it strong and competitive, ensuring that providers continue to have more negotiating power, healthier cash flow and revenue and – simply – more choice in how they want to practice medicine. The best way for this to happen is by narrowing the discount gap.

### **Mid-Tier Market Case Study – What’s Happening Today to Provider Revenue?**

In one market, mid-tier market payers had a discount gap 15 points less than the dominant payer. Because of this gap, the mid-tier payers collectively **lost 30%** of their enrollment to that market-dominant payer from 2005-2007 as the dominant payer leveraged its significant discount advantage to drive down their premiums and administrative fees.

#### **Three reasons why a competitive mid-tier payer market is important for a healthcare provider’s business.**

1. As the mid-market loses, so do providers. Any shift of members from mid-tier insurers to market dominant payers sets up a domino effect whereby the mid-tier shrinks and eventually disappears, and providers are left with only one choice in their market - and left to pay the deepest discounts with no leverage or negotiating power.
2. The mid-market represents payer diversity – a range of varying health plans representing diverse members and plan designs, **not** a one size fits all. This payer diversity allows providers to select contracts that may be more in line with their business philosophy. For example, mid-market insurers and self-insured plan administrators may support more flexible, progressive plans that focus on wellness, health coaching and other more innovative programs. *Payer diversity gives providers a more diverse influx of patients.*
3. Payer diversity brings revenue diversity. When providers have more choice and potential sources of income, they have more leverage. Providers have the power to pick and choose contracts and negotiate discounts.

This shift from mid-tier to dominant insurer had an adverse impact on providers as well. As Table 1 illustrates, with the dominant insurer demanding a much deeper discount for the same members, providers **lost \$113 million** in revenue from the member shift to deeper discounts through the dominant payer.

(All figures in \$ Million)	2006	2007	Total
Original reimbursement from middle market payers	\$179	\$235	\$414
Reimbursement now at a 15-point deeper discount, by the market dominant payer	\$130	\$171	\$301
Cost to providers of the market shift	(\$49)	(\$64)	(\$113)

Source: Private survey of middle market payers.

### Mid-Tier Market Case Study Revisited – What Could Happen by Narrowing the Discount Gap?

Table 1 above shows how providers lost \$113 million in revenue when members shifted to the dominant payer and the mid-tier market got much weaker. Remember, the shift will take place unless something is done. Dominant payers will eventually get their premiums down low enough to force a market shift unless the mid-tier payers can compete.

So, what if the mid-tier payers had a narrower discount gap – say, instead of a 15 point discount gap they were within 3 points of the market dominant payer?

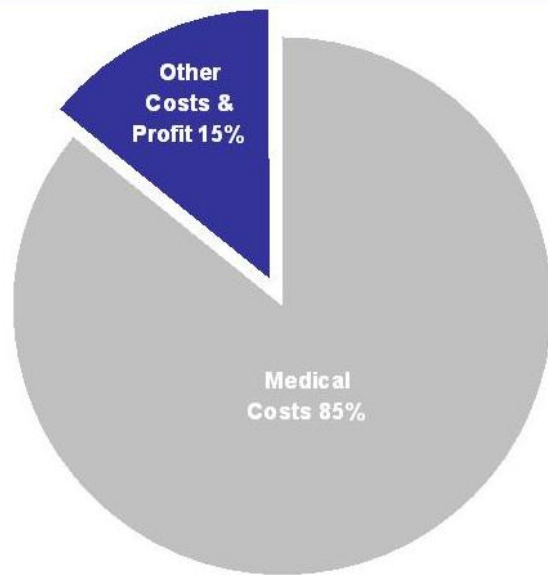
Table 2 shows the revenue result if the discount gap was only 3 points, and as a result members *remained* with the mid-tier payers. In this scenario, the providers actually turned a \$113 million loss into a **\$23 million gain**.

(All figures in \$ Million)	2006	2007	Total
Original reimbursement from middle market payers	\$179	\$235	\$414
Reimbursement if lives shift to the market dominant payer (15 pt gap)	\$130	\$171	\$301
Reimbursement if lives remain with the middle market payers (3 pt gap)	\$140	\$184	\$324
<b>Benefit to providers of a narrower discount gap</b>	<b>\$10</b>	<b>\$13</b>	<b>\$23</b>

A provider might think that keeping the discount gap wide is essential in order to maintain current revenue levels, but the reality is that the rest of the market can't retain their membership at discounts that are so dramatically lower than the dominant payer. In this example, the reimbursement levels reflected in line 1 of the above table are no longer sustainable. Providers in the market need to choose between keeping discount gaps wide and settling for the reimbursement levels reflected in line 2, or narrowing the gap and realizing higher reimbursement levels as shown in line 3.

### The Importance of Medical Cost

To keep and grow their membership, mid-market payers need to compete effectively with large payers. They can – and do – compete on the basis of products and services, but with such dramatic differences in discounts this is no longer enough. Why? Because as figure 3 illustrates, all other components of an insurance premium dwarf in comparison to medical cost.



Source: Milliman USA, *Health Plan Administrative Cost Trends, 2004*

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**Figure 3 - The role of medical cost in health plan administrative costs**

Whether a health plan sponsor will opt for a fully insured plan and pay a monthly premium, or self-insure and pay a monthly fee, it's easy to see how a sizeable discount advantage can lead to a dramatic cost advantage for large payers at the expense of smaller ones whose discounts are far less favorable.

A provider's best bet is to help keep the mid-tier payer market healthy. Because medical costs account for the lion's share of a health plan's administrative costs, the most critical step to a competitive mid-tier market is a reasonable gap in discounts. With that cap narrowed to, say, within 3 points of the market's dominant payer, mid-sized payers can more effectively compete on the basis of products and services. This means health plan sponsors will less likely shift their members to dominant insurers, and providers will retain bargaining power, revenue and payer diversity.

### Summary

Providers are facing difficult choices in the marketplace, and choices for the long-term need to be strategic. As stated in the AMA report, "If not corrected, the imbalances in the marketplace will have serious negative long-term consequences for the health care system."

Balancing the market means bolstering the mid-tier market, helping the mid-tier insurers and plan administrators to retain and even increase enrollment, and ensuring that providers have choice – choice when it comes to the discounts they offer and the health plan designs their patients utilize.

Both mid-market payers and providers need to work together to make their business viable and healthy for the long-term. By receiving better discounts from providers, the mid-market can offer better premiums or administrative fees, enrich their benefit plans and improve benefit design. This leads to a more diverse market representing payer and revenue diversity for providers and the ability to practice medicine on their own terms.